

You Can't Always Get What You Want ... Final Rules Provide Medical Loss Ratio Definitions and Process

On December 7, 2011, the Department of Health and Human Services ("HHS") published in the Federal Register two final regulations (the "Regulations") addressing certain elements of the medical loss ratio ("MLR") requirements. Specifically the Regulations amend provisions governing mini-med and expatriate plans, revise how rebates may be issued in the group markets, and allows some implementation costs associated with the International Classification of Diseases – Tenth Revision ("ICD-10") conversion to be counted as a clinical expense. Perhaps most controversial is what the Regulations do not change: agent and broker compensation and fraud prevention activities continue as administrative costs for MLR calculations.

Background. The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act (the "Health Reform Legislation")¹, stipulates that for plan years beginning after September 23, 2010 (for plans that run with calendar year, these changes were mandatory beginning January 1, 2011), health plans offering coverage in the group or individual markets, including grandfathered plans (but excluding self-insured plans), must report to the HHS the proportion of premium dollars spent on clinical services as compared to the percentage spent on administrative services. Each health plan must keep its annual non-medical costs lower than 15 percent of premium revenue for the large group market and 20 percent for the small group and individual market.²

On December 1, 2010, HHS published final interim regulations ("Interim Rules") detailing requirements for satisfying the MLR standards.³ These rules included disclosure and reporting requirements, the methodology for MLR calculation and rebates, processes for MLR waivers, and enforcement mechanisms.⁴ While most of the Interim Rules continue unaltered by the Regulations, a few significant issues are clarified.

Mini-Med and Expatriate Policies. The Regulations acknowledge the challenges of applying MLR limitations to mini-med and expatriate policies due to the unique structure of these types of plans. Mini-med plans generally involve lower incurred claims due to high deductibles and limited coverage, while also having higher enrollee turnover and shorter enrollment periods.⁵ Similarly, expatriate plans require increased administrative costs resulting from providing international access to providers, maintaining emergency evacuation services, and navigating



Visit our special webpage on [Health Reform IMPACT](#).

Events

View upcoming seminars and speaking engagements on our [website](#).

Services

- [Healthcare Regulatory](#)
- [Healthcare Information Technology](#)
- [Healthcare Litigation](#)
- [Healthcare Fraud and Abuse](#)
- [Insurance and Managed Care](#)

Connect With Us



¹ The Patient Protection and Affordable Care Act, Pub. L. 111-148 (March 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152 (March 30, 2010).

² Under the Health Reform Legislation (at §1304(b)), a small group employer is defined as 1-100 employees and a large group employer is more than 100 employees. However, since this is a change from the previous statutory definitions, states may continue to classify an employer with up to 50 employees as a small employer until 2016.

³ 75 Fed. Reg. 74864 (Dec. 1, 2010).

⁴ Please see "[The Devil is in the Details: Interim Final Rules Provide Medical Loss Ratio Definitions and Process](#)" published January 7, 2011.

⁵ 76 Fed. Reg. 76574, 76575 (December 7, 2011).

operational and legal issues in different countries.⁶ Under the Interim Rules, HHS required issuers of these plans to submit data regarding the cost structures of these plans to HHS quarterly, while allowing both types of plans to multiply their medical costs (the numerator of the MLR calculation) by 2.0 to calculate MLR. After reviewing the data, HHS announced in the Regulations that HHS is phasing out this provision for mini-med plans, such that for 2012 the multiplier is 1.75, then 1.5 in 2013 and 1.25 in 2014.⁷ Beginning in 2014, setting annual dollar limits for coverage is banned under the Health Reform Legislation such that these types of policies will not be available in any event. For expatriate plans, the Regulations allows the 2.0 adjustment to continue in 2012 and in each following year.

Rebates. While the Interim Rules required health plans to distribute rebates directly to each subscriber, HHS received a number of comments expressing concern about the logistics and potential tax implications of such payments being made to individual enrollees rather than through the group policyholder. Under the Regulations, plans may provide rebates directly to the group policyholder so long as the insurer gets written assurance that the group policyholder will use the funds for the benefit of current subscribers and provided that the plan gives notice of rebates to current subscribers as well as to the group policyholders.⁸ The notice must include details as to the MLR purpose, calculation and rebate, as well as describe how the rebate will be handled and/or allocated.⁹ HHS requests comments as to whether this notice requirement should be extended beyond plans that owe rebates and also if the notice should include information regarding the previous year's MLR results such that a subscriber could evaluate the trend for the issuer regarding MLR.¹⁰

Allowing a plan to pay the group policyholder rather than the individual subscriber avoids potential tax consequences for the enrollee. Specifically, the potential tax consequences were that, with the increase of policy premiums being paid with pre-tax money, the payment of refunds to enrollees potentially would result in those rebates qualifying as wages and therefore taxable income.¹¹ Should that occur, insurers might be responsible for determining tax withholdings on such individual rebates. To remedy this, the Regulations allow insurers to provide rebates to the group policyholder such that those rebates may be used for lower premiums or in other ways that are not taxable.

ICD-10 Implementation Costs

Beginning October 1, 2013, all health providers will be required to use ICD-10 coding for submission of claims to the federal government. Since most health plans use the ICD coding system as well, the industry as a whole must invest significant resources into implementation. The ICD-10 system will allow for dramatically increased detail related to diagnosis and procedure coding. While the Interim Rules allowed quality improvement activities to be included with medical costs, satisfying the requirements for quality improvement are daunting.¹² HHS received various comments

⁶ *Id.* at 76576.

⁷ *Id.* at 76575.

⁸ *Id.* at 76580.

⁹ *Id.* Note that the notice requirements differ depending if the plans are subject to ERISA.

¹⁰ *Id.* at 76581.

¹¹ *Id.* at 76579.

¹² An expense that would otherwise be a non-claims expense must satisfy one of the foregoing categories and must be all of the following to be counted as a quality improvement activity: 1) designed to improve health quality; 2) designed to increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements; 3) directed toward individual enrollees or incurred for the benefit of specified segments of enrollees or designed to

related to whether ICD-10 implementation could be considered an activity that improves healthcare quality.¹³ Some argued that the coding has no impact on treatment or on patient outcomes and is designed for administrative efficiency; others pointed to ICD-10 as allowing increased sharing of data, thereby assisting quality improvement activities and care coordination.¹⁴

In response to the comments, HHS determined that ICD-10 implementation serves a dual role as both administrative and clinical in nature. As a result, the Regulations allow health plans to count ICD-10 conversion costs as medical costs in 2012 and 2013, but cap the medical cost component at 0.3 percent of the plan's earned premium.

Administrative Costs: Fraud Prevention Activities and Agent and Broker Compensation

Perhaps the most controversial elements of the Regulations involve the continued exclusion of fraud prevention activities and agent/broker compensation from clinical expenses. The Regulations re-affirm that, while medical claim payments that are recovered through fraud detection programs can be used to adjust incurred claims amounts, fraud prevention activities are characterized for MLR purposes as administrative.¹⁵ In addition, the Regulations fail to include any discussion of the Interim Rule's determination that all agent and broker compensation is administrative. This categorization led members of the House of Representatives to introduce a bill last spring that, if passed as introduced, would exclude agent and broker compensation from the MLR calculations.¹⁶

In late November, the National Association of Insurance Commissioners ("NAIC") adopted a resolution urging (1) Congress to amend the Health Reform Legislation so as to "preserve consumer access to agents and brokers," and (2) HHS to "more appropriately classify producer compensation" under the MLR. The resolution noted a prior NAIC finding that "a significant portion" of insurance producer activities are dedicated to consumer advocacy and service and therefore justifies classifying "an appropriate portion of producer compensation as a health care quality expense" for MLR purposes. The resolution was sponsored by Tennessee Commissioner of Commerce and Insurance Julie Mix McPeak and 20 other state insurance commissioners.

If you have any questions about this issue of *Health Reform IMPACT*, please contact any of the attorneys in our Healthcare Practice Group listed below.

Also, please [click here](#) to visit our special website for Health Reform IMPACT.

provide health improvements to a population beyond those enrolled in coverage as long as no additional costs are incurred due to the non-enrollees; AND 4) grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies or other national recognized healthcare quality organizations.

¹³ Id. at 76577.

¹⁴ Id. at 76578.

¹⁵ Id. at 76577.

¹⁶ See H.R. 1206, "Access to Professional Health Insurance Advisors Act of 2011. Cosponsored by 149 representatives, the bill current sits with the Subcommittee on Health.

Bass, Berry & Sims Insurance and Managed Care Attorneys

Elisa E. Harris

(615) 742-6553

eharris@bassberry.com

Angela Humphreys

(615) 742-7852

ahumphreys@bassberry.com

Robins H. Ledyard

(615) 742-6259

rledyard@bassberry.com

T. Scott Noonan

(615) 742-6273

snoonan@bassberry.com

T. Stephen C. Taylor

(615) 742-7758

staylor@bassberry.com

Bob F. Thompson

(615) 742-6262

bthompson@bassberry.com

Elizabeth S. Warren

(615) 742-7719

ewarren@bassberry.com

The materials contained herein have been abridged from the statutory sources and should not be construed or relied upon for legal advice. Readers are urged to consult legal counsel concerning particular situations and specific legal questions.

To ensure compliance with requirements imposed by the IRS, we inform you that this message is not intended to be used, and cannot be used, by the addressee or any other person for the purpose of avoiding penalties that may be imposed under the Internal Revenue Code.

Nashville | Memphis | Knoxville

bassberry.com